

## **L-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED SERVICES**

### **L-210.1 TECHNICAL AND PROFESSIONAL COMPONENTS**

For any given lab test, no more than one provider may be reimbursed for the technical component of a service and no more than one provider may be reimbursed for the professional component.

#### **L-210.11 DPA 2211 Claim Form**

Payment to an independent laboratory includes both the technical and professional components. Payment will not be made to a practitioner for the interpretation of any tests performed and billed by an independent laboratory.

- = Independent laboratories may not bill the Department for lab tests done during an inpatient stay. The all inclusive rate that the hospital receives is considered to cover all services provided during the inpatient stay.

#### **L-210.12 DPA 2360 Claim Form**

Providers using the DPA 2360 claim form to bill for laboratory services may be paid for the technical component, the professional component or the global service (technical and professional). The Place of Service Code, which is entered in Field 24 B on the claim, determines which component(s) are to be paid. In addition, hospitals billing fee-for-service must use a modifier (in the MOD Box) when the Place Code is E (Emergency Room). Modifier T denotes "Technical" only and P denotes "Complete" (both Technical and Professional components).

Hospitals may bill fee-for-service for lab tests performed in the Outpatient Department or the Emergency Room. For the Outpatient Department, if the tests are interpreted by a salaried physician, Place Code 3 or 11 (Office) is to be used and the Global fee will be paid. If interpreted by a non-salaried physician, Place Code 2 or 22 (Outpatient) is to be used and the Technical fee paid. For the Emergency Room, Place Code E with Modifier P must be used for the Global and Place Code E with Modifier T for the Technical only fee. Hospitals should not bill fee-for-service for the Professional Component only. Hospitals should not bill fee-for-service for any lab tests done for in-patients.

- = When the hospital bills only for the Technical Component, the non-salaried physician may bill for the interpretation (Professional Component). Physicians use Place Codes C (Outpatient Hospital) or E (Emergency Room) and NO modifiers to bill for the interpretation. Physicians may not bill for the technical component only.

Pathologists may bill for the Professional Component for lab tests done for in-patients as long as the pathologist is not salaried by the hospital. Place Code 1 or 21 is used for the interpretation.

\_\_\_ Federally Qualified Health Clinics (FQHC), clinics and physicians who have laboratories in their offices may bill for the Global service when the tests are performed by their own laboratory. Place Code 3 or 11 is to be used to denote the Global service. These providers may not bill for laboratory tests collected and sent to another laboratory. In addition, payment will not be made to a second physician for interpretation of the same test(s).

## **L-210.2 MULTIPLES OF THE SAME TEST ON THE SAME DAY**

### **L-210.21 Independent Laboratories**

In order for an independent laboratory to bill for multiples of the same test performed on the same date of service, the laboratory must use both the CPT code for the test being performed and the appropriate unlisted code. The CPT code for the test being performed is placed in the procedure code portion of the service section for test #1 and the name of the test or a description is placed in the procedure description field. The charge for the first test is placed in the provider charge field. The appropriate unlisted procedure (example 87999) is placed in the procedure code field of the next service section. The name(s) and number of the additional test(s) must be shown in the procedure description field and one charge, which includes all the additional tests billed under the unlisted code, is to be entered in the charge field. If there is not adequate space on the billing form to describe the additional service(s), either a narrative description of the test(s) or test results must be attached to the claim.

### **L-210.22 Hematology Tests for All Other Providers**

A practitioner may bill for multiples of hematology services by using the days/unit field. When multiples of a hematology service are performed, the practitioner enters a 4 digit code in the days/unit field (example: 0004 for 4 tests within a 24 hour time period). If a quantity greater than 5 is placed in the Days/Units field, either the test results or a narrative explanation of the services must be attached to the claim.

A hospital billing fee for service for multiple hematology services is to use the same procedure as that described for a practitioner.

### **L-210.23 Pathology Services for All Other Providers**

A practitioner may bill for multiples of pathology services by using the Days/Units field. When multiples of a pathology service are performed, the practitioner enters a 4 digit code in the Days/Units field (example: 0004 for 4 tests within a 24 hour time period). If a quantity greater than 5 is placed in the Days/Units field, either the test results or a narrative explanation of the services must be attached to the claim.

Certain laboratory tests which are not reasonably performed more than once on the same service date, for the same participant, are limited to a quantity of one, e.g., Pap Smears, DNA testing. If more than one of these services is repeated on the same day, the unlisted code is to be shown for the additional test(s) and tests results attached to the claim.

A hospital billing fee for service for multiple pathology services is to use the same procedure as that described for a practitioner.